(x) Consultant qualifications, functions, and responsibilities.

(xi) The provision of home dialysis support services, if offered (see § 405.2163(e)).

(2) The physician-director of the facility is designated in writing to be responsible for the execution of patient care policies. If the responsibility for day-to-day execution of patient care policies has been delegated by a physican director to (or, in the case of a self-dialysis unit, to another licensed health practitioner) a registered nurse, the physican-director provides medical guidance in such matters.

(3) The facility policy provides that, whenever feasible, hours for dialysis are scheduled for patient convenience and that arrangements are made to accommodate employed patients who wish to be dialyzed during their nonworking hours.

(4) The governing body adopts policies to ensure there is evaluation of the progress each patient is making toward the goals stated in the patient's long term program and patient's care plan (see § 405.2137(a)). Such evaluations are carried out through regularly scheduled conferences, with participation by the staff involved in the patient's care.

(g) *Standard: medical supervision and emergency coverage.* The governing body of the ESRD dialysis and/or transplant facility ensures that the health care of every patient is under the continuing supervision of a physician and that a physician is available in emergency situations.

(1) The physician responsible for the patient's medical supervision evaluates the patient's immediate and long-term needs and on this basis prescribes a planned regimen of care which covers indicated dialysis and other ESRD treatments, services, medications, diet, special procedures recommended for the health and safety of the patient, and plans for continuing care and discharge. Such plans are made with input from other professional personnel involved in the care of the patient.

(2) The governing body ensures that there is always available medical care for emergencies, 24 hours a day, 7 days a week. There is posted at the nursing/monitoring station a roster with the names of the physicians to be called, when they are available for emergencies, and how they can be reached.

(h) *Standard: medical staff.* The governing body of the ESRD facility designates a qualified physician (see § 405.2102) as director of the ESRD services; the appointment is made upon the recommendation of the facility's organized medical staff, if there is one. The governing body establishes written policies regarding the development, negotiation, consummation, evaluation, and termination of appointments to the medical staff.

[41 FR 22511, June 3, 1976. Redesignated at 42 FR 52826, Sept. 30, 1977, and amended at 43 FR 48952, Oct. 19, 1978; 51 FR 30362, Aug. 26, 1986; 52 FR 36934, Oct. 2, 1987]

§ 405.2137 Condition: Patient long-term program and patient care plan.

Each facility maintains for each patient a written long-term program and a written patient care plan to ensure that each patient receives the appropriate modality of care and the appropriate care within that modality. The patient, or where appropriate, parent or legal guardian is involved with the health team in the planning of care. A copy of the current program and plan accompany the patient on interfacility transfer.

(a) *Standard: patient long-term program.* There is a written long-term program representing the selection of a suitable treatment modality (i.e., dialysis or transplantation) and dialysis setting (e.g., home, self-care) for each patient.

(1) The program is developed by a professional team which includes but is not limited to the physician director of the dialysis facility or center where the patient is currently being treated, a physician director of a center or facility which offers self-care dialysis training (if not available at the location where the patient is being treated), a transplant surgeon, a qualified nurse responsible for nursing services, a qualified dietitian and a qualified social worker.

(2) The program is formally reviewed and revised in writing as necessary by

a team which includes but is not limited to the physician director of the dialysis facility or center where the patient is presently being treated, in addition to the other personnel listed in paragraph (a)(1) of this section at least every 12 months or more often as indicated by the patient's response to treatment (see §405.2161(b)(1) and §405.2170(a)).

(3) The patient, parent, or legal guardian, as appropriate, is involved in the development of the patient's long-term program, and due consideration is given to his preferences.

(4) A copy of the patient's long-term program accompanies the patient on interfacility transfer or is sent within 1 working day.

(b) *Standard: patient care plan.* There is a written patient care plan for each patient of an ESRD facility (including home dialysis patients under the supervision of the ESRD facility; see §405.2163(e)), based upon the nature of the patient's illness, the treatment prescribed, and an assessment of the patient's needs.

(1) The patient care plan is personalized for the individual, reflects the psychological, social, and functional needs of the patient, and indicates the ESRD and other care required as well as the individualized modifications in approach necessary to achieve the long-term and short-term goals.

(2) The plan is developed by a professional team consisting of at least the physician responsible for the patient's ESRD care, a qualified nurse responsible for nursing services, a qualified social worker, and a qualified dietitian.

(3) The patient, parent, or legal guardian, as appropriate, is involved in the development of the care plan, and due consideration is given to his preferences.

(4) The care plan for patients whose medical condition has not become stabilized is reviewed at least monthly by the professional patient care team described in paragraph (b)(2) of this section. For patients whose condition has become stabilized, the care plan is reviewed every 6 months. The care plan is revised as necessary to insure that it provides for the patients ongoing needs.

(5) If the patient is transferred to another facility, the care plan is sent with the patient or within 1 working day.

(6) For a home-dialysis patient whose care is under the supervision of the ESRD facility, the care plan provides for periodic monitoring of the patient's home adaptation, including provisions for visits to the home by qualified facility personnel to the extent appropriate. (See §405.2163(e).)

(7) Beginning July 1, 1991, for a home dialysis patient, and beginning January 1, 1994, for any dialysis patient, who uses EPO in the home, the plan must provide for monitoring home use of EPO that includes the following:

(i) Review of diet and fluid intake for indiscretions as indicated by hyperkalemia and elevated blood pressure secondary to volume overload.

(ii) Review of medications to ensure adequate provision of supplemental iron.

(iii) Ongoing evaluations of hematocrit and iron stores.

(iv) A reevaluation of the dialysis prescription taking into account the patient's increased appetite and red blood cell volume.

(v) A method for physician followup on blood tests and a mechanism (such as a patient log) for keeping the physician informed of the results.

(vi) Training of the patient to identify the signs and symptoms of hypotension and hypertension.

(vii) The decrease or discontinuance of EPO if hypertension is uncontrollable.

[41 FR 22511, June 3, 1976. Redesignated at 42 FR 52826, Sept. 30, 1977, as amended at 43 FR 48952, Oct. 19, 1978; 59 FR 1284, Jan. 10, 1994; 59 FR 26958, May 25, 1994]

§405.2138 Condition: Patients' rights and responsibilities.

The governing body of the ESRD facility adopts written policies regarding the rights and responsibilities of patients and, through the chief executive officer, is responsible for development of, and adherence to, procedures implementing such policies. These policies and procedures are made available to patients and any guardians, next of